Editorials

Thoughts on Rationing Medical Care

THE OREGON EXPERIENCE described by Crawshaw and colleagues elsewhere in this issue brings into sharp focus what happens when the dollars available for high technology patient care simply do not meet the need. The state of Oregon is prohibited from borrowing money for public services, and there is no sales tax. The state cannot spend money that it does not have. When a young boy on the Medicaid program needed a bone marrow transplant to treat his leukemia, the money simply was not there. The boy died and there was an outcry. In their update of the Oregon approach to this and other ethical problems in health care, Crawshaw and associates describe one option for dealing with the inevitable rationing that will be needed, particularly for expensive high technology patient care.

Given that scientific progress has occurred and will continue to occur, and given that finite resources will never be able to satisfy infinite demands and expectations, some rationing of patient care is inescapable. At present the approach is, to say the least, crude and insensitive. It is to let the economic winds prevail. If you can pay for it, you can have it, and the corollary is that if you cannot pay for it, you do not get it. The tragedy is that with this approach the poor fall between the cracks and are unfairly disadvantaged in that they are deprived of what can be had by those who have access to the resources that are available. This becomes a serious disadvantage in view of deregulation of health care in the private sector and reduced funding of increasingly regulated care in the public sector. The private sector cannot be expected to be in business to finance care for the poor, and the government can no longer afford to finance equal access to care for those who cannot pay for it. This is patently unfair and in many ways may not even be good public policy.

When one thinks about it, rationing means that someone has to decide what resources will be available for care, and someone has to decide who gets what. These decisions are de facto being made now by the payers in the private sector—business, industry, insurance—and by federal, state, and local governments. They decide what their dollars can or will pay for and what they can or will not. In spite of rhetoric to the contrary, all these payers are of necessity self serving, leaving patients who do not have their own resources at a disadvantage when they need expensive care—that is, when their own self-interest is involved. In this situation the power lies where the dollars are, and the public, not to mention patients, has little to say about how many dollars will be available for health care in any state or any community, or how these dollars will be used. The fact is that the self-interest of patients or the public has little chance for expression or influence.

In the final analysis it is the consumer, patient or not, who pays for all health care in one way or another and who has the most at stake in whatever is done or not done about rationing it. How can consumers, or the public, be involved meaningfully in the decisions that are made, decisions that may come to affect their lives so personally? Are these decisions really too important to be left to self-interests, whether in the public or private sectors of society? It is in this connection that the Oregon experience, or perhaps it should be called an experiment, seems so important. Under the leadership of Crawshaw and colleagues, the principle of the town meeting is being adapted to develop community-based citizen discussion and recommendations concerning some of the "life and death" decisions that are necessitated by modern medicine. Oregon Health Decisions and Citizens' Health Decisions, USA should be followed with interest. They just might be on the right track.

MSMW

Pertussis—A Disease and a Vaccine That Are Not Going Away

IN MARCH 1982, diphtheria and tetanus toxoids and pertussis vaccine (DTP) cost about 15 cents per dose for public sector providers and 37 cents for private sector providers. There were three vaccine manufacturers. The vaccine that had come into routine use in pediatric practice during the late 1940s and early 1950s was considered the major cause of a dramatic reduction in the number of reported pertussis cases from an annual average of 110,847 cases reported between 1945 and 1950 to 1,248 cases reported in 1981. Intermittent controversy about vaccine safety in the medical community had been raised almost since pertussis vaccines were developed in the 1930s, and alternative vaccines had been sought.[1] In April of 1982, a television program entitled "DPT—Vaccine Roulette" aired in Washington, DC, and was excerpted on the "Today" show. The program ignited a controversy about the risks and benefits of whole-cell pertussis vaccines among the United States lay public that had flared in the United Kingdom and Japan since the mid-1970s. Since 1982, the debate has become more acrimonious. Between 1978 and 1981, an average of about two lawsuits alleging damage from the vaccine was filed annually against DTP manufacturers. Between 1982 and 1986, the number of lawsuits filed increased dramatically, peaking at 255 in 1986. Vaccine prices have paralleled the increase in lawsuits.[2] As of February 13, 1989, the price of DTP was $8.46 for public providers and $11.03 for private providers. One of the three manufacturers dropped out of the market in 1984.

Two issues are at the heart of the controversy. First, do the benefits of vaccine truly exceed the risks? Second, if the benefits exceed the risks, why are the risks "so high"—why do we not have a better, safer pertussis vaccine?

The controversy about benefits concerns whether pertussis disease is serious enough to merit prevention and whether whole-cell pertussis vaccine is truly effective. Are the morbidity and mortality from pertussis disease significant? As noted by Cherry and co-workers elsewhere in this issue, complications from pertussis such as pneumonia and seizures are frequent among reported cases, particularly in the very young. Although these data may be skewed somewhat toward more severe cases, even those who think that pertussis is a trivial disease quote hospital admission rates of 1% or higher.[3] This is not the characteristic of a benign disease.

Although the efficacy of some whole-cell vaccines was demonstrated in the United States, it was established most convincingly in trials conducted by the Medical Research